MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03488 — 03482

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Cecil — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Cecil
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton — 07,1
   d. STREET ADDRESS: R.D. # 5 Box 112
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert — Middle: E. — Last: Barrow

4. DATE OF DEATH: Month: March — Day: 21, — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 1, 1919

9. AGE (In years last birthday): 47 yrs.
   IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Foreman

10b. KIND OF BUSINESS OR INDUSTRY: Budd Co.

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert R. Barrow

14. MOTHER'S MAIDEN NAME: Eva Rink

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes
    (If yes give war or dates of service): WW2

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Dorothy M. Barrow, Elkton, Md. — Address: R.D. 5

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Hepatic Failure	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	Carcinoma of Liver, Metastatic	3 mths
DUE TO (c)	Carcinoma of Colon	3 months

1538

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 1-30, 1967 to March 21, 1967, that (I) (we) last saw the deceased alive on March 21, 1967, and that death occurred at 11:55 M, from the causes and on the date stated above.

22a. SIGNATURE: Rolando A. Najera M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3/24/67

22c. PHYSICIAN'S NAME (Type): Rolando A. Najera

22d. ADDRESS: 105 E. Main St. Elkton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/25/67

23c. NAME OF CEMETERY OR CREMATORY: Brookview Cemetery

23d. LOCATION (City, town or county) (State): Rising Sun, Md.

24. FUNERAL DIRECTOR: Ralph E. Hicks — ADDRESS: Hicks Home for Funerals, Elkton, Md.

25a. REC'D BY REGISTRAR: MAR 29 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03489 — 03483

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: Cecil — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rising Sun
   c. LENGTH OF STAY IN 1b: 2 yrs.
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Calvert Manor Nursing Home

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Harford
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Jarrettsville
   d. STREET ADDRESS: Jarrettsville Road
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. **NAME OF DECEASED** (Type or print): First: John — Middle: Henry — Last: Beading

4. **DATE OF DEATH**: Month: March — Day: 14, — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 2/2/1884

9. AGE (In years last birthday): 83 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Saw mill

11. BIRTHPLACE (County & State, or foreign country): Harford County, Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Beading

14. MOTHER'S MAIDEN NAME: Elizabeth Harman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
    (If yes give war or dates of service): ---

16. SOCIAL SECURITY NO.: 215-12-3370A

17. INFORMANT: Mrs. Lillie M. Johnson — Address: Jarrettsville Road Forest Hill, Md. 21050

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Aortic Stenosis — 2
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY — Hour e.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from ..... 19..... to March 19 67 that (I) (we) last saw the deceased alive on March 14 19 67 and that death occurred at 4 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Ernest W. Seiter M.D.

ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: March 19, 1967

22c. PHYSICIAN'S NAME (Type): Ernest W. Seiter, M.D.

22d. ADDRESS: 28 W. Cherry St. Rising Sun, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/18/1967

23c. NAME OF CEMETERY OR CREMATORY: St. Ignatius

23d. LOCATION (City, town or county) (State): Hickory, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Charles E. Kurtz Jarrettsville, Md. 21084

25a. RECD BY REGISTRAR DATE: MAR 17 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A1S (4)
2DM 5-63

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03490 — 03484

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH a. COUNTY: Cecil — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland — b. COUNTY: Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point — c. LENGTH OF STAY IN 1b: 1 Yr 8 Mo 8d	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): VA Hospital, Perry Point, Md.	d. STREET ADDRESS: 3616 Forrest Hill Road — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print): First ERNEST — Middle G — Last BOUIS	4. DATE OF DEATH: Month March — Day 18, — Year 1967
5. SEX: Male — 6. COLOR OR RACE: White — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: 5-16-95 — 9. AGE (In years last birthday): 71 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver — 10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country): Baltimore, Md. — 12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Clarence G. Bouis (D)	14. MOTHER'S MAIDEN NAME: Hattie Moore (D)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): WW I	16. SOCIAL SECURITY NO.: 213-05-78-86 — 17. INFORMANT Address: VA Hospital Records, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Pulmonary Edema, Acute, Severe	1-2-days
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Arteriosclerotic Heart Disease	Years
DUE TO		
(c)	Broncho- Pneumonia	2 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 10, 1965, to March 18, 1967, that (I) (we) last saw the deceased on [illegible] and that death occurred at 9:00 AM, from causes and on the date stated above.

22a. SIGNATURE: H. E. Connor M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒		22b. DATE SIGNED: 3-18-67
22c. PHYSICIAN'S NAME (Type): H. E. CONNOR, M.D.	22d. ADDRESS: VAH., Perry Point, Md.	

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE THEREOF: 3/21/67	23c. NAME OF CEMETERY OR CREMATORY: Druid Ridge	23d. LOCATION (City or Town): Pikesville	(County) (State): Balto. Md
24. FUNERAL DIRECTOR: LORING BYERS	ADDRESS: 8728 Liberty Rd. Balto. Md.	25a. REC'D BY REGISTRAR DATE: MAR 21 1967	25b. REGISTRAR'S SIGNATURE: J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03491 — 03485

1. PLACE OF DEATH
   a. COUNTY: Cecil — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
   c. LENGTH OF STAY IN 1b: 4 mos 19 days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Montgomery
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wheaton
   d. STREET ADDRESS: 11602 Bucknell Drive
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HENRY — Middle M. — Last CARPENTER

4. DATE OF DEATH: Month March — Day 1 — Year 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: 8-21-92

9. AGE (In years last birthday): 74 yrs.
   IF UNDER 1 YEAR: Months — Days
   IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrician

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Concord, N. Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Martin (D)

14. MOTHER'S MAIDEN NAME: Mary (D)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
   (If yes give war or dates of service): WW I

16. SOCIAL SECURITY NO.: 578-34-7438

17. INFORMANT — Address: VA Hospital Records, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Acute pulmonary edema
   DUE TO
   (b): Arteriosclerotic heart disease with myocardial fibrosis
   DUE TO
   (c):
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4200
   INTERVAL BETWEEN ONSET AND DEATH: Sudden -----

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (this hospital) attended the deceased from Oct. 13, 19 66, to March 1, 19 67, that I last saw the deceased alive on March 1, 19 67, and that death occurred at 2:50 am, from causes and on the date stated above.

22a. SIGNATURE: Joaquin R. Garcia — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 3-1-67

22c. PHYSICIAN'S NAME (Type): J. R. GARCIA, M.D.

22d. ADDRESS: VA Hospital, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 3-3-67

23c. NAME OF CEMETERY OR CREMATORY: ALEX. NAT. CEMETERY

23d. LOCATION (City or Town) (County) (State): ALEXANDRIA — VA.

24. FUNERAL DIRECTOR — ADDRESS: Lee Funeral Home, 4th & Mass.Ave., NE., Wash. DC

25a. REC'D BY REGISTRAR — DATE: MAR 6 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03492 03486

1. PLACE OF DEATH
a. COUNTY: Cecil
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 21 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: 811 N. Adams Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROBERT Middle J. Last CHRISTY

4. DATE OF DEATH: Month March Day 16 Year 19 67

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 10-17-95

9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck driver, ret.

10b. KIND OF BUSINESS OR INDUSTRY: Lumber Company

11. BIRTHPLACE (County & State, or foreign country): Harford Co., Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Christy (D)

14. MOTHER'S MAIDEN NAME: Sarah Christy (D)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WW I

16. SOCIAL SECURITY NO. 057-14-8963

17. INFORMANT Address: VA Hospital Records, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia
DUE TO
(b): Arteriosclerotic heart disease
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 2 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (X) (this hospital) attended the deceased from Feb. 23, 19 67, to March 16, 1967, [illegible] saw the deceased alive on [illegible] and that death occurred at 6:00 ☒ p.m. ☐ from causes and on the date stated above.

22a. SIGNATURE: J. R. Garcia M.D.
M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 3-17-67

22c. PHYSICIAN'S NAME (Type): J. R. GARCIA, M.D.

22d. ADDRESS: VAH, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3-22-67

23c. NAME OF CEMETERY OR CREMATORY: Union Methodist Cemetery

23d. LOCATION (City or Town) (County) (State): Aberdeen Harford Md

24. FUNERAL DIRECTOR ADDRESS: Bullock Funeral Home, Havre de Grace, Md.

25a. RECD BY REGISTRAR DATE: MAR 20 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03493 — 03487

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 17 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL end give nearest town): Elkton
d. STREET ADDRESS: 373 W. Main St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: David — Middle: L. — Last: Cleaves
4. DATE OF DEATH: Month: March — Day: 9, — Year: 19 67
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb. 19, 1900
9. AGE (In years last birthday): 67 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): --
10b. KIND OF BUSINESS OR INDUSTRY: DuPont Co.
11. BIRTHPLACE (County & State, or foreign country): Delaware
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John H. Cleaves
14. MOTHER'S MAIDEN NAME: Margaret A. Ford
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): WW 2
16. SOCIAL SECURITY NO.: 221-07-6415
17. INFORMANT: Mrs. David L. Cleaves — Address: 373 W. Main St., Elkton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral artery hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 12 hours
443X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Hypertensive Cardiovascular Disease — Years
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes Mellitus
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour e.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 3/5/, 19 67, to 3/9/, 19 67, that (I) (we) last saw the deceased alive on 3-5- 19 67, and that death occurred at 5 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Tillman D. Johnson — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3-9-67
22c. PHYSICIAN'S NAME (Type): Tillman D Johnson M.D
22d. ADDRESS: 123 Singerly Ave, Elkton, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/12/67
23c. NAME OF CEMETERY OR CREMATORY: Elkton Cemetery
23d. LOCATION (City, town or county) (State): Elkton, Md.
24. FUNERAL DIRECTOR: Ralph E. Hicks — ADDRESS: Hicks Home for Funerals, Elkton, Md.
25a. REC'D BY REGISTRAR DATE: MAR 14 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

Item 18 Film 387 4-19-67

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03494

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03488

1. PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town): Perryville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Trailer Camp - Susquehanna Avenue

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporote limits, write RURAL ond give neorest town): Perryville 07-1
d. STREET ADDRESS: Wm. Zurlin's Trailer Camp
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: THOMAS — Middle: J. — Lost: COCKRELL, Jr
4. DATE OF DEATH: Month: 3 — Doy: 6 — Year: 19 67
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 3-6-1922
9. AGE (In years lost birthdoy): 45 yrs. — IF UNDER 1 YEAR: Months / Doys — IF UNDER 24 HRS.: Hours / Min.
10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): UNemployed
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (Stote or foreign country): Alexander, Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Thomas J. Cockrell, Sr.
14. MOTHER'S MAIDEN NAME: Gladys Ewald
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) W W II (If yes give wor or dotes of service)
16. SOCIAL SECURITY NO.: 225-34-0649
17. INFORMANT Address: Cunningham Funeral Home, Alexander, Virgini

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): No cause of death determined — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b): due to
DUE TO
(c): Advanced decomposition
Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse lost. 7953

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20o. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion deoth resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.
EXAMINER'S NAME (Type): WERNER U. SPITZ, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county)
22. DATE SIGNED: 3-7-67

23o. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 3-13-1967
23c. NAME OF CEMETERY OR CREMATORY: Alexander National Cem.
23d. LOCATION (City or Town) (County) (State): Alexander, Virginia

24. FUNERAL DIRECTOR ADDRESS: Howard H. Hubbard, 4107 Wilkens Ave. 21229
25o. REC'D BY REGISTRAR DATE: MAR 10 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03495 — 03489

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH a. COUNTY: Cecil — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland — b. COUNTY: —
b. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): Perry Point	c. LENGTH OF STAY IN 1b: 21 days / 5 yrs. 8 mos. — c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): Baltimore 3014
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Veterans Administration Hospital	d. STREET ADDRESS: 5115 Balto. Nat'l. Pike — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print): First JOHN — Middle P. — Last Del Giudice Jr. — 4. DATE OF DEATH: Month March — Day 28 — Year 19 67	
5. SEX: Male — 6. COLOR OR RACE: White — 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: 8-6-21 — 9. AGE (In years last birthday): 45 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer — 10b. KIND OF BUSINESS OR INDUSTRY: Electric — 11. BIRTHPLACE (County & State, or foreign country): Baltimore, Md. — 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: John Del Giudice — 14. MOTHER'S MAIDEN NAME: Nellie Lang	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): WW II — 16. SOCIAL SECURITY NO.: 216-18-7945 — 17. INFORMANT Address: VA Hospital Records, Perry Point, Md.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: ------- — 491X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (X) (this hospital) attended the deceased from April 6, 1960, to March 28, 1967, that (I) (we) last saw deceased alive on [illegible], and that death occurred at 5:00 a.m. from causes and on the date stated above.

22a. SIGNATURE: S. Goldgraben — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒	22b. DATE SIGNED: 3-28-67	
22c. PHYSICIAN'S NAME (Type): S. GOLDGRABEN, M.D.	22d. ADDRESS: VAH, Perry Point, Md.	

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE THEREOF: 3- 31 67	23c. NAME OF CEMETERY OR CREMATORY: Moreland Mem. Park	23d. LOCATION (City or Town): Baltimore	(County): (State): Maryland
24. FUNERAL DIRECTOR: Wm. Cook-Brooks Funeral Home, Towson, Md.	ADDRESS: Wm. Cook-Brooks Towson	25a. REC'D BY REGISTRAR DATE: MAR 31 1967	25b. REGISTRAR'S SIGNATURE: J. Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03496

CERTIFICATE OF DEATH

03490

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 25 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 1604 Park Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MYRON — Middle M — Last EMERSON

4. DATE OF DEATH: Month March — Day 17 — Year 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2-24-99

9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Switchboard Operator

10b. KIND OF BUSINESS OR INDUSTRY: Emersonian Apts

11. BIRTHPLACE (County & State, or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John L. Emerson (D)

14. MOTHER'S MAIDEN NAME: Eva M. Saunders (D)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes give war or dates of service): WWI

16. SOCIAL SECURITY NO.: 569-01-2883

17. INFORMANT Address: VA Hospitals Records, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia
DUE TO
(b): Kimmelstiel - Wilson Disease
DUE TO
(c): Diabetes Mellitus
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
260X
INTERVAL BETWEEN ONSET AND DEATH: 10 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Pulmonary Edema - - Hypertensive Heart Disease

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ~~I~~ (this hospital) attended the deceased from Feb. 20, 19 67, to March 17, 1967, that ~~I (saw)~~ ~~(last saw the deceased alive on)~~ and that death occurred at 8:50 AM, from causes and on the date stated above.

22a. SIGNATURE: Alfred S. Gillis — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐

22b. DATE SIGNED: 3-17-67

22c. PHYSICIAN'S NAME (Type): A. G. Gillis, M.D.

22d. ADDRESS: VA Hospital, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/21/67

23c. NAME OF CEMETERY OR CREMATORY: Balto. Nat. Cem.

23d. LOCATION (City or Town) (County) (State): Baltimore, Md.

24. FUNERAL DIRECTOR: Schimunek Funeral Home ADDRESS: 3331 Brehms Lane, Balto, Md

25a. REC'D BY REGISTRAR DATE: MAR 22 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03497

CERTIFICATE OF DEATH

03491

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 173 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): VA Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: VIRGINIA — b. COUNTY: Fairfax
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FALLS CHURCH
d. STREET ADDRESS: 704 Villa Ridge
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First THOMAS — Middle J. — Last HAYES

4. DATE OF DEATH: Month March — Day 18, — Year 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-18-88

9. AGE (In years last birthday): 78 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S. ARMY

10b. KIND OF BUSINESS OR INDUSTRY: U.S.ARMY

11. BIRTHPLACE (County & State, or foreign country): Ironton, Ohio

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Thomas J. Hayes (D)

14. MOTHER'S MAIDEN NAME: Susanna T. Davis (D)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Yes — 6-12-12 to 7-15-50

16. SOCIAL SECURITY NO.: 225-46-4963

17. INFORMANT — Address: VA Hospital Records Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Broncho-Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 5-10 days
DUE TO
(b): Arteriosclerosis, Generalized - Severe — Years
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4500

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9-26-66, 19__, to 3-18-67, 19__, that (I) (we) last saw the deceased alive on [illegible] 19__, and that death occurred at 1:00 p.m., from causes and on the date stated above.

22a. SIGNATURE: S Goldghaben — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 19 Mar. 67

22c. PHYSICIAN'S NAME (Type): S GOLDGHABEN, M.D.

22d. ADDRESS: VA Hospital - Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE THEREOF: 3/21/67

23c. NAME OF CEMETERY OR CREMATORY: West Point Military Cem.

23d. LOCATION (City or Town) (County) (State): West Point. N. York.

24. FUNERAL DIRECTOR — ADDRESS: Tarring Funeral Home, Aberdeen, Maryland

25a. REC'D BY REGISTRAR DATE: MAR 21 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

JUSTUS

Items 18-21 Film 387 4-5

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03498

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03492

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Childs
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Elk Paper Company

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
d. STREET ADDRESS: RD #3, Box 420
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: RAY — Middle: H. — Last: JUSTICE
4. DATE OF DEATH: Month: March — Day: 21 — Year: 19 67
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan. 15, 1934
9. AGE (In years last birthday): 33 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Elk Paper Co.
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Roy Justice
14. MOTHER'S MAIDEN NAME: Georgie Stacy
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 226-38-2428
17. INFORMANT: Address: Mrs. Gladys Justice, Elkton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple extreme injuries
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Fell into pulp beater
20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 3 21 1967
20d. INJURY OCCURRED While at work ☒ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Factory
20f. (City or town): Childs (County): Cecil (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Petty M.D.
EXAMINER'S NAME (Type): Charles S. Petty
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county):

22. DATE SIGNED: 3/23/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/26/67
23c. NAME OF CEMETERY OR CREMATORY: Justice Cemetery
23d. LOCATION (City or Town) (County) (State): Grundy, Virginia

24. FUNERAL DIRECTOR: Ralph E. Hicks
ADDRESS: Hicks Home for Funerals, Elkton, Md.
25a. REC'D BY REGISTRAR: MAR 29 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03499

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03493

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Del. — b. COUNTY: New Castle
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Newark
d. STREET ADDRESS: 408 Arbour Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: David — Middle: Mack — Last: Lilly

4. DATE OF DEATH: Month: 3 — Day: 13 — Year: 1967

5. SEX: M.

6. COLOR OR RACE: W.

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10-20-88

9. AGE (In years last birthday): 78 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. - Blasting Eng.

10b. KIND OF BUSINESS OR INDUSTRY: Road Constn.

11. BIRTHPLACE (State or foreign country): West Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Bob Lilly

14. MOTHER'S MAIDEN NAME: AMANDA AKERS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 232-16-7294

17. INFORMANT: Kenneth Lilly (Son) — Address: Newark, De.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 30 min.
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):
4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John M. Byers, M.D.

EXAMINER'S NAME (Type): John M. Byers, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑

Address (Street, city, town, or county)

22. DATE SIGNED: 3-13-67
Elkton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/17/67

23c. NAME OF CEMETERY OR CREMATORY: Blue Ridge Mem. Gardens

23d. LOCATION (City or Town) (County) (State): Beckley, West Virginia

24. FUNERAL DIRECTOR: R. T. Jones — ADDRESS: Newark, Delaware

25a. REC'D BY REGISTRAR: DATE: MAR 17 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03500

CERTIFICATE OF DEATH

03494

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 2 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East
d. STREET ADDRESS: 9 Walnut St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HERMAN Middle BOYER Last LOCKARD

4. DATE OF DEATH: Month March Day 6 Year 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 1, 1904

9. AGE (In years last birthday): 62 yrs.

IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Brick Maker

10b. KIND OF BUSINESS OR INDUSTRY: Fire Brick Mfg.

11. BIRTHPLACE (County & State, or foreign country): Cecil County Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: David Lockard

14. MOTHER'S MAIDEN NAME: Emma Boyer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 216-05-6566

17. INFORMANT: Mrs. Joanne L. Harrison
Address: 9 Walnut St. North East, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio - Respiratory failure — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO (b): Pulmonary Infarction — ?
DUE TO (c): Pulmonary Fibrosis — ?
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 525X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from March 6, 1967, to March 6, 1967, that (I) (we) last saw the deceased alive on March 6 1967, and that death occurred at 9:05 A.M, from causes and on the date stated above.

22a. SIGNATURE: Rolando A. Najera M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3/6/67

22c. PHYSICIAN'S NAME (Type): Rolando A. Najera

22d. ADDRESS: 105 E. Main St. Elkton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Mar. 9, 1967

23c. NAME OF CEMETERY OR CREMATORY: North East Methodist

23d. LOCATION (City or Town) (County) (State): North East Cecil Md.

24. FUNERAL DIRECTOR: Grant Funeral Home — Paul R. Crouch
ADDRESS: Box 22 North East, Md.

25a. REC'D BY REGISTRAR DATE: MAR 15 1967

25b. REGISTRAR'S SIGNATURE: Charles Jaeger

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #7 Film #G387 3/27/67 pc

03501

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03495

1. PLACE OF DEATH
   a. COUNTY: Cecil — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Ohio
   b. COUNTY:
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bellefontaine
   d. STREET ADDRESS: Box 206
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First DELBERT — Middle FAYE — Last LOGAN

4. DATE OF DEATH: Month March — Day 10 — Year 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: Oct. 28/12

9. AGE (In years last birthday): 54 yrs.
   IF UNDER 1 YEAR: Months — Days
   IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sign Painter

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Leesburg Ohio

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Jester Logan

14. MOTHER'S MAIDEN NAME: Emma Kerns

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Roberts Fun Home, Dayton Ohio — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple Extreme Injuries.
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Port II of item 18.): Pedestrian struck by truck.

20c. TIME OF INJURY Hour ~~AM~~ p.m. Month, Day, Yeor: 3/ 10 1967

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Street

20f. (City or town): Perryville — (County): Cecil — (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Petty M.D.

EXAMINER'S NAME (Type): Charles S. Petty

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county)

22. DATE SIGNED: 3/12/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE THEREOF: Mar 13 67

23c. NAME OF CEMETERY OR CREMATORY: East Leesburg Cem Ohio

23d. LOCATION (City or Town): Ohio — (County) — (State)

24. FUNERAL DIRECTOR: Philip Herwig Sons — ADDRESS: 2024 Orleans Street 31

25a. REC'D BY REGISTRAR DATE: MAR 15 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03502 03496

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use os the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Calvert
c. LENGTH OF STAY IN 1b: 19 Months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Calvert Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Charlestown
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Nettie Middle: B. Last: Lovejoy

4. DATE OF DEATH: Month: Mar Day: 4 Year: 1967

5. SEX: Female
6. COLOR OR RACE: Cau.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 2-28-1879
9. AGE (In years last birthday): 88 yrs.
IF UNDER 1 YEAR / IF UNDER 24 HRS. — Months / Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give wor or dotes of service):
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Albert Cooper Address: Charlestown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebro Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: Hrs.
DUE TO (b): Arterio Sclerotic Hypertensive CVD — Yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify thot (I) (this hospital) ottended the deceased from Mar 2, 1967, to March 4, 1967, that (I) (we) last saw the deceased olive on Mar 2 1967, and that death accurred at 7:20 M, from causes and on the dote stated obave.

22a. SIGNATURE: G. H. Richards Jr. M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/8/67
22c. PHYSICIAN'S NAME (Type): G. H. Richards Jr.
22d. ADDRESS: Port Deposit, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/8/1967
23c. NAME OF CEMETERY OR CREMATORY: Ebenezer Cemetery
23d. LOCATION (City or Town) (County) (State): Rising Sun, Maryland.

24. FUNERAL DIRECTOR: Lee A. Jefferson & Son ADDRESS: Perryville, Md.
25a. REC'D BY REGISTRAR DATE: MAR 10 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03503

CERTIFICATE OF DEATH

03497

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Cecil.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cecilton. 07-1
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ELDRIDGE — Middle W. — Last LUSBY.

4. DATE OF DEATH: Month March — Day 4, — Year 1967

5. SEX: Male — 6. COLOR OR RACE: White — 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: October 20,1906

9. AGE (In years last birthday): 60 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Farmer.

10b. KIND OF BUSINESS OR INDUSTRY: Own Farm.

11. BIRTHPLACE (County & State, or foreign country): Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: S.Wills Lusby.

14. MOTHER'S MAIDEN NAME: Helen M. Schrack

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No. (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 221-18-7197

17. INFORMANT: Henry Syle, — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosc erotic Heart disease — INTERVAL BETWEEN ONSET AND DEATH: 5 years
4200
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

Probable immediate cause of death was Ball-Valve thrombus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 15 Jan, 1967, to 4 Mar, 1967, that (I) (we) last saw the deceased alive on 4 Mar, 1967, and that death occurred at 6:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Wallace Obenshain — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 7 Mar 67

22c. PHYSICIAN'S NAME (Type): Wallace Obenshain. M.D.

22d. ADDRESS: Cecilton, Md. 21913

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial.

23b. DATE THEREOF: Mar.8,1967

23c. NAME OF CEMETERY OR CREMATORY: St. Stephens Cemetery.

23d. LOCATION (City, town or county) (State): Earleville, Cecil Co; Md.

24. FUNERAL DIRECTOR: Edward Fellows, — ADDRESS: Millington, Md.21651

25a. REC'D BY REGISTRAR DATE: MAR 13 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03504

CERTIFICATE OF DEATH

03498

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Cecil — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
   c. LENGTH OF STAY IN 1b: 3 wks.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Cecil
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton R.D. # 3 — 07-1
   d. STREET ADDRESS: (Fair Hill)
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Martha — Middle: R. — Last: Mackey

4. DATE OF DEATH: Month: March — Day: 6, — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: May 28, 1881

9. AGE (In years last birthday): 85 yrs.
   IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (County & State, or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Madison Watson

14. MOTHER'S MAIDEN NAME: Martha Elizabeth Lambert

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: John E. Mackey, Rising Sun, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.
1538
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Cancer of Colon — 1 year.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

2Da. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1/27, 1967, to 3/6, 1967, that (I) (we) last saw the deceased alive on 3/6, 1967, and that death occurred at 12:40 M, from the causes and on the date stated above.

22a. SIGNATURE: Peter Stavrakis — M.D. — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 3/8/67.

22c. PHYSICIAN'S NAME (Type): Peter Stavrakis

22d. ADDRESS: Elkton Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/9/67

23c. NAME OF CEMETERY OR CREMATORY: Sharps Cemetery

23d. LOCATION (City, town or county) (State): Fair Hill, Md.

24. FUNERAL DIRECTOR — ADDRESS: Ralph E. Hicks, Hicks Home for Funerals, Elkton, Md.

25a. REC'D BY REGISTRAR DATE: MAR 14 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03503 — 03499

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 15 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): VA Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Penna. — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Curtisville
d. STREET ADDRESS: 176 Bessemer Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Jean — Middle: R. — Last: NIETO

4. DATE OF DEATH: Month: March — Day: 28, — Year: 19 67

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White		11-29-23	43 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Registered Nurse	Nursing	Madison, Pa.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Matthew Rodgers	Sarah Seabury

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give wor or dotes of service)	16. SOCIAL SECURITY NO.	17. INFORMANT — Address
Yes	Korean	168-28-68-62	VA Hospital Records - Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 week
DUE TO
(b)
DUE TO
(c)
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3 13 67, 19__ to 3 28 67, 19__, that (I) (we) last saw the deceased alive on ~~xxxxxxxxxxxxxx~~, and that death occurred at 7:40 p.m. from causes and on the date stated above.

22a. SIGNATURE: S. Goldgraben — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 3 29 67
22c. PHYSICIAN'S NAME (Type): S. GOLDGRABEN, M.D.
22d. ADDRESS: VA Hospital - Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	April 1, 1967	Lakewood Cemetery	Dorseyville, Pa

24. FUNERAL DIRECTOR — ADDRESS: Patterson Funeral Home, Perryville, Md.
25a. REC'D BY REGISTRAR DATE: APR 5 1967
25b. REGISTRAR'S SIGNATURE: [illegible]

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03506

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03500

1. PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 137 Collins Avenue

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
d. STREET ADDRESS: 137 Collins Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: ANDERSON — Middle: — Last: PAINE

4. DATE OF DEATH: Month: 3 — Day: 6 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Dec.19,1916

9. AGE (In years last birthday): 50 ? yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Ala.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jack Paine

14. MOTHER'S MAIDEN NAME: Ollie Rush

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 419-18-1556

17. INFORMANT: Dorothy Mae Hutchinson — Address: 137 Collins St Elkton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute alcoholic intoxication
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
· 3220
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Purulent bronchitis and pulmonary emphysema

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.

EXAMINER'S NAME (Type): WERNER U. SPITZ, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county)

22. DATE SIGNED: 3-6-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/13/67
23c. NAME OF CEMETERY OR CREMATORY: Providence Cem.
23d. LOCATION (City or Town) (County) (State): Elkton, Maryland

24. FUNERAL DIRECTOR: Eclark Bell — ADDRESS: 909 Poplar St.

25a. REC'D BY REGISTRAR DATE: MAR 15 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15ME (5) 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03507

CERTIFICATE OF DEATH

03501

1. PLACE OF DEATH a. COUNTY: Cecil — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE / b. COUNTY: District of Columbia
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point — c. LENGTH OF STAY IN 1b: 9 mos 18 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47-3
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Veterans Administration Hospital	d. STREET ADDRESS: 3196 18th St., N.E. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First: FRANK — Middle: ARTHUR — Last: PILGRIM
4. DATE OF DEATH	Month, Day: March 16, — Year: 1967
5. SEX	Male
6. COLOR OR RACE	Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	
8. DATE OF BIRTH	4-2-74
9. AGE (In years last birthday)	92 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	Navy man retired
10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country)	Massachusetts
12. CITIZEN OF WHAT COUNTRY?	U.S.A.
13. FATHER'S NAME	Unknown
14. MOTHER'S MAIDEN NAME	Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	Yes — S A W
16. SOCIAL SECURITY NO.	578-20-1620
17. INFORMANT — Address	VA Hospital Records, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral Thrombosis

491X

DUE TO (b) Terminal Broncho- Pneumonia

DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ~~I~~ (this hospital) attended the deceased from June 1, 1966, to March 16, 1967, ~~xxxxxxxx that (I) (we) last saw the deceased alive on xxxxxxxxxxxx 19xxx~~, and that death occurred at 11:50 pm, from causes and on the date stated above.

22a. SIGNATURE: Stephen A. Hegedus M.O. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 3-17-67

22c. PHYSICIAN'S NAME (Type): S. A. Hegedus, M.D.

22d. ADDRESS: VA Hospital, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
	3/22/67	Arlington	Arlington, VA

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
John T. Rhines Co	3015-12th NE Wash DC	DATE MAR 22 1967	J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03508

CERTIFICATE OF DEATH

03502

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point, Maryland
c. LENGTH OF STAY IN 1b: 25 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): VA Hospital, Perry Point, Maryland

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 2917 E. Baltimore
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First THEODORE Middle P. Lost RAKOWSKI

4. DATE OF DEATH: Month MARCH Day 26 Year 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12-12-01

9. AGE (In years last birthday): 65 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman -Retired

10b. KIND OF BUSINESS OR INDUSTRY: Salesman

11. BIRTHPLACE (County & State, or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Rakowski

14. MOTHER'S MAIDEN NAME: Kunugunda Shultz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WW II

16. SOCIAL SECURITY NO.: 212 07 87 38

17. INFORMANT: Address: VA Hospital Records, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia
DUE TO
(b): Hypertension cardio-vascular disease
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 5-10 days / years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ~~(I)~~ (this hospital) attended the deceased from 3-2- , 19 67 , to 3-26-67 , 19 , ~~that (I) (we) last saw the deceased alive on~~ , and that death occurred at 2:50 P.M., from causes and on the date stated above.

22a. SIGNATURE: Stephen A. Hegedus M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 3-27-67

22c. PHYSICIAN'S NAME (Type): STEPHEN A. HEGEDUS, M.D.

22d. ADDRESS: VA Hospital, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE THEREOF: 3/29/1967

23c. NAME OF CEMETERY OR CREMATORY: Holy Rosary

23d. LOCATION (City or Town) (County) (State): Baltimore, Md.

24. FUNERAL DIRECTOR: HENRY W. JENKIN &Co.,

ADDRESS: 4905 York Road, Baltimore, Maryland

25a. REC'D BY REGISTRAR DATE: MAR 28 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03509

CERTIFICATE OF DEATH

03503

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fredricktown
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First JANE — Middle — Last REDMOND

4. DATE OF DEATH: Month March — Day 31, — Year 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: May, 25, 1881

9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Ireland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: David Clarke.

14. MOTHER'S MAIDEN NAME: Elizabeth English

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No.
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 163-01-1805

17. INFORMANT: Martin Redmond, — Address: Georgetown, Md. 21930

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thronbosis — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks

332x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Cerebral arteriosclerosis — 2 years
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): none

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7 Mar, 19 67, to 31 Mar, 19 67, that (I) (we) last saw the deceased alive on 31 Mar 19 67, and that death occurred at 11:30 AM from the causes and on the date stated above.

22a. SIGNATURE: Wallace Obenshain — M.D. ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 2 Apr 67

22c. PHYSICIAN'S NAME (Type): Wallace Obenshain. M.D.

22d. ADDRESS: Cecilton, Md. 21913

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: April, 3, 1967

23c. NAME OF CEMETERY OR CREMATORY: Holy Cross Cemetery.

23d. LOCATION (City, town or county): Philadelphia, (State): Pa.

24. FUNERAL DIRECTOR: Edward Fellows and Son.

ADDRESS: Millington, Md. 21651

25a. REC'D BY REGISTRAR DATE: APR 4 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03510

CERTIFICATE OF DEATH

03504

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 17 days / 3 yr 2 mos
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Connecticut — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Norwich
d. STREET ADDRESS: 17 Braddway
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARGARET — Middle E. — Last RYAN

4. DATE OF DEATH: Month March — Day 3 — Year 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7-11-73

9. AGE (In years last birthday): 93 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nurse

10b. KIND OF BUSINESS OR INDUSTRY: Health

11. BIRTHPLACE (County & State, or foreign country): Nova Scotia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jeremiah Ryan

14. MOTHER'S MAIDEN NAME: Mary Scott McDonald

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WW I

16. SOCIAL SECURITY NO.: 217-54-9515

17. INFORMANT — Address: VA Hospital Records, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Recurrent Adeno-Carcinoma of Rectum with — INTERVAL BETWEEN ONSET AND DEATH
154X
DUE TO
(b): Metastasis to Liver — 5 Years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES XX NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ~~(I)~~ (this hospital) attended the deceased from Dec. 17, 19 65, to March 3, 19 67, ~~I last (I) (two) last~~ saw the deceased alive on ~~xxxxxxxxxxxx~~ 19~~xxx~~ and that death occurred at 1:50 pm, from causes and on the date stated above.

22a. SIGNATURE: Edgar E. Folk III — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 3-5-67

22c. PHYSICIAN'S NAME (Type): Edgar E. FOLK III M.D.

22d. ADDRESS: VA Hospital, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL

23b. DATE THEREOF: Mar. 6 1967

23c. NAME OF CEMETERY OR CREMATORY: Swan Point

23d. LOCATION (City or Town) (County) (State): Providence, Rhode Island

24. FUNERAL DIRECTOR: PETER J. BARRETT — ADDRESS: 1328 Warwick Avenue Rhode Island

25a. REC'D BY REGISTRAR DATE: MAR 9 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

0351; 03505

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point, Maryland
c. LENGTH OF STAY IN 1b: 107 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): VA Hospital, Perry Point, Md.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
d. STREET ADDRESS: Rt 1, Box 170
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joseph — Middle: Louis — Last: Storath

4. DATE OF DEATH: Month: March — Day: 26 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: September 20, 1899

9. AGE (In years last birthday): 67 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cab driver

10b. KIND OF BUSINESS OR INDUSTRY: Taxi-cab

11. BIRTHPLACE (County & State, or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Junius Storath

14. MOTHER'S MAIDEN NAME: Katherine Koos

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give wor or dotes of service): WWII

16. SOCIAL SECURITY NO.: 219-07-8096

17. INFORMANT — Address: VA Hospital Records, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of lung — INTERVAL BETWEEN ONSET AND DEATH: 2 years
163X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Metastases to Thoracic Spine & Cachexia
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Yeor Haur a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Hame, form, factory, street, affice bldg., etc.)

20f. (City or tawn) (County) (Stote)

21. I certify that (I) (this hospital) attended the deceased from 12/9/ , 19 66 , to 3/26 , 19 67 that (I) (we) last saw the deceased alive on [illegible] 19[illegible] and that death occurred at 1:20p M, from causes and on the date stated above.

22a. SIGNATURE: Stephen A. Hegedus — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): STEPHEN A. HEGEDUS, M.D.

22d. ADDRESS: VA Hospital, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF: 3/29/67

23c. NAME OF CEMETERY OR CREMATORY: Angel Hill Cemetery

23d. LOCATION (City or Town) (County) (State): Havre deGrace, Harford, MARYLAND

24. FUNERAL DIRECTOR — ADDRESS: Cunningham Son Havre de Grace, Md

25a. REC'D BY REGISTRAR DATE: MAR 29 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/63

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03512 03506

1. PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL CONOWINGO
c. LENGTH OF STAY IN 1b: 50 YEARS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): AT HOME

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: CECIL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CONOWINGO
d. STREET ADDRESS: RURAL
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First GEORGE — Middle Lewis — Last TAYLOR

4. DATE OF DEATH: Month MARCH — Day 26 — Year 1967

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: JAN. 18 1877

9. AGE (In years last birthday): 90 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMING

10b. KIND OF BUSINESS OR INDUSTRY: FARM

11. BIRTHPLACE (State or foreign country): N.J.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: JOHN TAYLOR

14. MOTHER'S MAIDEN NAME: FRANCES FLAHARTY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO

16. SOCIAL SECURITY NO.: 215-36-8378

17. INFORMANT: ETHEL TYSON — Address: EDGEWOOD MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CORONARY THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: INST

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): DIED SITTING IN CHAIR

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Henry V Davis M.D.

EXAMINER'S NAME (Type): HENRY V. DAVIS MD

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

Address (Street, city, town, or county): RT 1 SAPPALACE City MD

DATE SIGNED: 3/26/67

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 3-29-1967

22c. NAME OF CEMETERY OR CREMATORY: West Nottingham

22d. LOCATION (City, town, or county): Colora (State): Md.

23. FUNERAL DIRECTOR: Vernon E. McMullen — ADDRESS: Rising Sun, Md.

24a. REC'D BY REGISTRAR DATE: MAR 30 1967

24b. REGISTRAR'S SIGNATURE: J Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03513 — 03507

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Port Deposit
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): 32 N. Main Street

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland. — b. COUNTY: Cecil
c. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town): Port Deposit
d. STREET ADDRESS: 32 N. Main Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Alvia — Middle: E. — Last: Todd
4. DATE OF DEATH: Month: March — Day: 1, — Year: 19 67

5. SEX: Female
6. COLOR OR RACE: Cau.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 19,1890
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: ----------
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Benjamin F. Thomas
14. MOTHER'S MAIDEN NAME: Laurinda Fisher

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes give war or dates of service): ----------
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: Walter Todd Sr., Port Deposit, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 6hrs.
DUE TO (b): Arteriosclerosis Hypertensive H.V.D. — 20yrs
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** thot (I) (this hospitol) attended the deceased from 2-12, 1967, to 3-1, 1967, that (I) (we) last saw the deceased alive on 3-1 1967, and that death occurred at 9:15 M, from couses ond an the date stated above.

22a. SIGNATURE: [signature] M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/4/67
22c. PHYSICIAN'S NAME (Type): C. H. Richards Jr.
22d. ADDRESS: Port Deposit Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-5-1967
23c. NAME OF CEMETERY OR CREMATORY: West Nottingham Cem
23d. LOCATION (City or Town) (County) (State): Colora, Md.

24. FUNERAL DIRECTOR — ADDRESS: Lee A. Patterson & Son, Perryville, Md.
25a. REC'D BY REGISTRAR — DATE: MAR 7 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20 M 1/66

1 2

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03514

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03508

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 149 E. High Street

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
d. STREET ADDRESS: 149 E. High Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ALMEDA — Middle — Last WALKER
4. DATE OF DEATH: Month March — Day 16 — Year 19 67

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-11-1918
9. AGE (In years last birthday): ~~50~~ 48 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: HOME
11. BIRTHPLACE (State or foreign country): TERRAHUTE, IND.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: NO INFO.
14. MOTHER'S MAIDEN NAME: NO INFO.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give wor or dotes of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: MATTHEW E. WALKER — Address: NORTH EAST, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Cardiovascular Disease.
4221
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Charles S Petty M.D.
EXAMINER'S NAME (Type): Charles S. Petty
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county)

22. DATE SIGNED: 3/16/67

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 3-20-67
23c. NAME OF CEMETERY OR CREMATORY: NORTH EAST METH.
23d. LOCATION (City or Town) (County) (State): NORTH EAST CECIL MD.

24. FUNERAL DIRECTOR: TIPPIN FUNERAL HOME
ADDRESS: Robert Tippin ELKTON, MD.
25a. REC'D BY REGISTRAR DATE MAR 20 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03515

CERTIFICATE OF DEATH

03510

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Kent.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sassafras. 14-2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARTHA — Middle — Last WHITTINGTON.

4. DATE OF DEATH: Month March — Day 3, — Year 19 67

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: March, 20, 1891

9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home.

11. BIRTHPLACE (County & State, or foreign country): Queen's Anne's Co; Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Maria Hines.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No. (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 222-05-6783

17. INFORMANT: George Hines, — Address: Rural Millington, Md. 21651

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusoon — INTERVAL BETWEEN ONSET AND DEATH: 4 hours

4201

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclreotic heart disease. — years ?
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Near total blindness, Ca of Uterus (treated)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1 Mar, 1967 to 3 Mar, 1967, that (I) (we) last saw the deceased alive on 3 Mar 1967, and that death occurred at 4 PM from the causes and on the date stated above.

22a. SIGNATURE: Wallace Obenshain — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5 Mar 67

22c. PHYSICIAN'S NAME (Type): Wallace Obenshain. M.D.

22d. ADDRESS: Cecilton, Md. 21913

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: March, 8, 1967

23c. NAME OF CEMETERY OR CREMATORY: John Wesley Cemetery.

23d. LOCATION (City, town or county) (State): Sassafras, Kent Co; Md.

24. FUNERAL DIRECTOR: Edward Fellows,

ADDRESS: Millington, Md. 21651

25a. REC'D BY REGISTRAR DATE: MAR 9 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03516 03511

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Md. b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cecilton 07-1
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES Middle CARROLL Last WOOLEYHAN

4. DATE OF DEATH: Month March Day 29, Year 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept.12,1889

9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR Months: Days: IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Broker

10b. KIND OF BUSINESS OR INDUSTRY: Insurance

11. BIRTHPLACE (County & State, or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James A.Wooleyhan

14. MOTHER'S MAIDEN NAME: Mary E. Stradley.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes.
(If yes give war or dates of service): W.W. 1

16. SOCIAL SECURITY NO.: 480-03-3737

17. INFORMANT Address: Mrs. Isabel G.Wooleyhan, Cecilton, Md.21913

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: Several Days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Myocardial Infarction — Several Days
DUE TO (c): Mucous Coronary Occlusion — Several Days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ____, 19____, to ____, 19____, that (I) (we) last saw the deceased alive on ____ 19____, and that death occurred at ____M, from the causes and on the date stated above.

22a. SIGNATURE: Rolando Najera M.D. M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3/30/67

22c. PHYSICIAN'S NAME (Type): Rolando Najera. M.D.

22d. ADDRESS: Union Hospital

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: April,1,1967

23c. NAME OF CEMETERY OR CREMATORY: Bethel Cemetery.

23d. LOCATION (City, town or county) (State): Chesapeake City, Md.

24. FUNERAL DIRECTOR: Edward Fellows and Son.

ADDRESS: Millington, Md.

25a. REC'D BY REGISTRAR DATE: APR 4 1967

25b. REGISTRAR'S SIGNATURE: J.Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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